MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045245 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11371

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

FILED NOV 22 1963

1. PLACE OF DEATH
a. COUNTY - - -
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri
Length of stay in 1b: 16 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Brothers Hospital
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY - - -
c. CITY OR TOWN St. Louis
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 5240 Walsh
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Edwin Middle (n.m.i.) Last Bosche
4. DATE OF DEATH: Month November Day 16, Year 1963
5. SEX: M
6. COLOR OR RACE: W
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 11-10-1897
9. AGE (last birthday): 66
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Buyer
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Jacob Bosche
13b. MOTHER'S MAIDEN NAME: Marietta Betts
14. NAME OF HUSBAND OR WIFE: Bernice Bosche
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service - - -)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Bernice Bosche 5240 Walsh Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial failure with decompensation.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 4222H
INTERVAL BETWEEN ONSET AND DEATH: About 18 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Probable carcinoma head of pancreas with hemorrhage.

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from October 31, 1963 to Nov 17, 1963 and last saw her him alive on November 17, 1963
Death occurred at Nov 18, (1:22 a.m.) 1963 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M.D.
22b. ADDRESS 3606 Thurman
22c. DATE SIGNED 11/18/63

23a. BURIAL, CREMATION, REMOVAL (Specify): Entombment
23b. DATE: 11-19-63
23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS: HOFFMEISTER COLONIAL MORTUARY 6464 Chippewa SAW
25. DATE RECD. BY LOCAL REG.: NOV 18 1963
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
2	21	4	12
4	0		
5	1		
7	0		
8	2		
12	50-D		
	50		

BY AFFIDAVIT OF DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by ____________________, Student Embalmer No.________

working under my personal supervision.

Student________________________ Signed *John S. Dennehy*

Signature of Student Embalmer

Licensed Embalmer No. *4194*

P. O. Address *St. Louis, MO*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

~~Dr. John W. Dake~~

Dr. Weinsberg

Deaconess Brothers Clinic